Scottish Hospitals Inquiry Witness Statement of David Hall

I, David Hall, will say as follows:-

1 The facts and matters set out in this witness statement are within my own knowledge unless otherwise stated, and I believe them to be true to the best of my recollection.

2 This witness statement was prepared with the assistance of the solicitors for Currie & Brown, Keoghs LLP, following Teams calls to discuss my response to the Glasgow IV Questionnaire issued by the Inquiry on 27 January 2025 and supplemental questions issued by the Inquiry on 31 March 2025, but it is in my own words and sets out my recollection and understanding.

3 I refer to the project to design and construct the QEUH/RHC as the “Project” and I refer to NHS Greater Glasgow & Clyde as the “Board” throughout this witness statement.

4 As the key events took place several years ago at a time when I was working collaboratively with the Board Project Team, it is difficult to accurately recall the detail surrounding certain events or meetings that I have been asked about. I have set out to assist the Inquiry to the best of my ability when preparing this statement. Whilst I have knowledge that certain decisions were made by the Board, due to the passage of time I cannot specifically recall who within the Board made these decisions and, in some instances, due to Currie & Brown’s reduced remit following the award of the contract to design and build the hospitals to Multiplex in late 2009, was only aware of some decisions anecdotally. Where this is the case, I have tried to explain why I am unable to provide any more information and suggest who any such questions may be better directed to.

5 Where I refer to information supplied to me by other people, the source of the information is identified; facts and matters derived from other sources are true to the best of my knowledge and belief.

Personal details, professional background and experience

6 I am an experienced Project Manager and currently hold the post of Director of Projects at the University of Glasgow. To assist the Inquiry, I produce marked DH1 a copy of my CV, detailing my professional history and specialism.

7 By way of overview, I was an Architectural Trainee with GD Lodge & Partners between 1982 and 1985. I then worked as an Architectural Assistant with JG Wallace Architects between 1985 and 1989, during which I obtained a National Certificate in Building (1986) and a Higher National Certificate (HNC) in Architectural Technology (1988). I then worked as a Senior Architectural Technologist with The Miller Partnership for 3 years, Regional Surveyor with William Hill for 3 years, and Regional Projects Manager with Safeway Stores PLC between 1996 and 2000. I became a member of the Association of Project Management (MAPM) in 2000, a Member of the Chartered Institute of Builders (MCIOB) in 2006, and a Fellow of the Chartered Institute of Builders (FCIOB) in 2008.

8 In previous roles I gained significant experience working on complex projects such as the Safeway retail store at Greenock and large stadium developments such as Murrayfield and Nottingham Forest.

9 I was employed by Currie & Brown from 2000 to February 2016. During that time, I progressed from Senior Project Manager to Associate Director and ultimately became a Director of Project Management in the Glasgow office. I was

responsible for the line management of project managers and senior project managers working across a variety of commissions in both public and private sectors. This was in relation to large construction projects such as assisting RBS with their strategy for building in Glasgow City Centre, and Citygate in Newcastle. I also had experience of working on healthcare projects such as the Coatbridge and Airdrie Health Centres.

10 In September 2008, my work became solely focused on the commission of the Project. I remained full-time on the Project until around April 2015, after handover to the Board but prior to the hospital going live. During my time working on the Project my role was to support and assist the Board's Project Manager, Peter Moir, with things such as Project Management of the design development process, contract management and construction delivery. Peter would delegate duties for people to undertake. I am a Chartered Construction Project Manager by qualification and so my role was centred around the coordination of Project activities. I did not undertake any design responsibilities at all.

11 I have been asked to describe my day-to-day role and responsibilities and to describe how I supported and assisted the Project Manager. My role spanned a seven-year period, and the focus of my activity changed as the Project moved through design development and into construction during this period and so I set out my roles and responsibilities throughout at a high level below.

12 In the first year following the award of the building contract to Multiplex on 18 December 2009 my time was split between supporting and coordinating the process of design development of the hospital and the contract administration of the medical laboratory building as requested by Peter Moir. My day-to-day activities on design development included attendance at user group meetings with the design team, internal Project team meetings, and external meetings with statutory authorities such as building control and planning. As explained above and below, my role involved supporting only the coordination and management of

these activities and I did not have any input into developing or commenting on the design (and I was not qualified to do so). I also attended meetings held to administer the contract through design development including Early Warning Meetings, Programme Review Meetings and meetings with external parties such as Glasgow City Council in relation to planning and building control.

13 I have been asked to describe the design development process. The design development process for the Hospitals took place in the 12-month period from the award of the Building Contract to Multiplex in December 2009 and involved the Multiplex design team (Multiplex, Nightingales, ZBP etc) developing their initial bid proposal into a full RIBA Stage 4 design via a series of stakeholder meetings. The final output, Appendix K, formed the basis of the Board's instruction to commence construction.

14 I have been asked to set out the Project activities that I coordinated. Again, as my role spanned a long period of time, I set this out at a high level. During the design phase I supported the Board Project Managers, primarily Heather Griffin, in the coordination of user group meetings to progress the development of the RIBA Stage 4 design. During the construction phase, my activities focused on contract administration, coordinating responses to Early Warnings, and continuing to support design development and client change requests. In the latter stages, and beyond completion, my coordination activities focused on Group 5 equipment installation (which I understand is unrelated to the subject- matter of this Inquiry).

15 I have been asked to help the Inquiry understand more clearly what I was doing and was not doing during my time on the Project. Over the seven-year period from 2008 to 2015 and as noted elsewhere my activities focused on contract management in support of Peter Moir, the Board NEC Project Manager. This included construction programme reviews as required under the NEC form of contract to support acceptance activities by the Board, facilitating and managing the design reviews for clinical functionality carried out with the clinical user groups,

and administration of Early Warning Processes etc. Multiplex was responsible for the entire design of the hospitals, however the Board had a responsibility to review the clinical functionality. For elements of this, I had a delegated authority from Peter Moir to undertake that element of review, i.e. the review of clinical functionality only. I was not involved at all in technical commissioning, witnessing, or validation.

Currie & Brown's appointment as Lead Consultant

16 Currie & Brown was appointed as Lead Consultant following the acceptance of its tender submission in 2008 by the Board. I was not involved in Currie & Brown's tender or the negotiation of Currie & Brown's terms for the Project as this preceded my involvement in the Project. The development and agreement of the scope of service to be provided by Currie & Brown was undertaken primarily by Douglas Ross and James Hackett.

17 I have been asked to describe my understanding at the time of the scope of the role of Lead Consultant. The role in the initial pre-design stage was to develop the Employer's Requirements for the new Hospitals and the Medical Laboratory Building to support the procurement strategy which included a competitive dialogue process with evaluation outcome based upon the Most Economically Advantageous Tender (MEAT).

18 I was aware that the scope of Currie & Brown's services changed at the end of the pre-design phase of the Project. This change did not affect the Project Management support service that I was providing but it removed Currie & Brown's role of NEC Project Supervisor from that point which resulted in responsibility for inspection and witnessing transferring to Capita. I am unable to recall how and when I became aware of this change, however it would have been in 2010 and

would have been apparent at the latest when Capita were appointed into the NEC Project Supervisor role and began to have an involvement.

19 I have been asked to describe my understanding at the time of how the scope of Currie & Brown's role changed and to describe the impact of the change. At the end of the pre-design phase of the Project, in January 2010, Currie & Brown's role was significantly reduced to Cost and Project Management. The supervisor services were omitted from Currie & Brown's remit and instead separately contracted out by the Board (to Capita). The design services provided by Currie & Brown in the initial pre-design stage were not extended, with responsibility for technical design instead forming part of the Multiplex contract. Currie & Brown was not appointed as Lead Consultant following January 2010 because it no longer had any design responsibilities and that role was instead fulfilled by Multiplex (under the design and build form of contract) together with its own professional design team (which Currie & Brown was not part of).

20 I have been asked to describe the changes to Currie & Brown's role after the predesign and construction stage of the QEUH/RHC (2008-2009) and its role during the design and construction stage (2010-2015). My comments at paragraph 19 above set out my understanding of this.

21 I have been referred to the Board's letter to Currie & Brown dated 18 January 2010 (**Bundle 17, Document No.74, Page 2870)** which is referred to as the "Revised Fee Agreement". I have been referred to the text under the heading "Delegation of Duty" in the Revised Fee Agreement which states, "As the Board are undertaking the role of Project Manager we require to delegate a range of duties which will most likely mirror the attached schedules A-C. I propose that David and Mark meet with myself and Alan Seabourne to agree duties for both Project Manager and Cost Advisor, please let me know if you wish to undertake this task." I have been asked whether the meeting referred to took place and to describe the outcome and confirm whether a finalised schedule of duties was prepared and

signed. I cannot recall one specific meeting where Currie & Brown's duties were agreed and think that multiple meetings or discussions took place over a period of time which allocated duties across a number of staff. I also cannot recall a single schedule of agreed duties being prepared.

22 I have been asked what the rationale was for the Board's decision to appoint itself as NEC Project Manager and appoint a separate NEC Supervisor (Capita), which resulted in the Board issuing the Revised Fee Agreement to Currie & Brown. As I was not involved in contractual discussions, this is not something I have any knowledge of and is something that Peter Moir would have been able to comment on, and that Douglas Ross may be able to comment on in view of his involvement in the relevant contractual discussions.

23 I have been asked what impact the Board's decision to appoint itself as NEC Project Manager and appoint a separate NEC Supervisor had. The impact was that Capita was instead appointed NEC Supervisor and the scope of Currie & Brown's services was significantly reduced.

24 I have been asked whether, with the benefit of hindsight, this was the correct decision for the Board to have made. I find it difficult to comment on this. So far as I was concerned, there was nothing unusual about the Board's decision because this reflected the practices of the NHS Frameworks across Scotland at the time. The Board's appointed NEC Project Manager, Peter Moir, was an experienced architect with many years' experience in healthcare.

25 The Inquiry have raised questions about how the Memorandum of Understanding dated 6 April 2011 came to be signed by Currie & Brown. I am afraid I cannot comment on this as it was not within my remit at the time and I was not involved at all in that process.

26 I believe that the Memorandum of Understanding was within Douglas Ross' remit and that he dealt with that.

Project timeframe

27 Currie & Brown was involved in the Project over a number of years, covering several phases of the Project:

27.1 The Initial pre-design phase September 2008 to April 2009

27.2 The Competitive Dialogue phase April 2009 to September 2009

27.3 The bid evaluation phase September 2009 to October 2009

27.4 The Design and Construction Phase 2010 to 2015 – This phase included an initial 12-month process throughout 2010 to develop the design from the Multiplex bid document through to a RIBA Stage 4 design prior to the Contract being awarded to Multiplex. During this process design documents were prepared by Multiplex's design team and were ultimately included in Appendix K to the Contract. The aim of the process was to allow a final target price to be agreed for the Project.

28 I detail my involvement in each of these phases below. I worked alongside the Board Project Team throughout. I mostly worked with Alan Seabourne (Board Project Director up until 2013), David Loudon (who was Alan's replacement from 2013 onwards), and Peter Moir, (Board Assistant Project Director and NEC Project Manager). I also worked regularly with Heather Griffin who was the Board's Adult Hospital Project Manager. As part of the Board's Project

Management team, I also interacted frequently with senior members of the Multiplex team including, but not limited to, Mike Sharples (Project Director until his sad passing), Alastair Fernie (Project Director), Darren Pike (M&E Lead), Jim Murray (Design Manager) and Gavin Burnett (Design Manager). On a day- to-day basis I reported to Douglas Ross of Currie & Brown and Peter Moir of the Board. The working relationships between us all were professional in a collaborative working environment as required by the NEC form of contract.

Initial Pre-design Stage: September 2008 to April 2009

29 During the initial pre-design stage Currie & Brown appointed a team of technical advisory sub-consultants (the "Technical Team") consisting of:

29.1 Buchan Associates (Medical Planners)

29.2 HLM Architects (Architects for the Adult Hospital exemplar design)

29.3 BMJ Architects (Architects for the Children's Hospital exemplar design)

29.4 Wallace Whittle (M&E Engineers)

29.5 URS (Civil and Structural Engineers)

Employers' Requirements and Exemplar Design

30 With the assistance of the Technical Team, Currie & Brown worked collaboratively with key Board stakeholders to develop a set of Employers' Requirements ("ERs"). The ERs are a set of documents that outline the employer's requirements (or when referring to exemplar designs, expectations) for a project and which must be complied with in the design and construction of the Project.

31 During the Pre-design phase, my role was primarily to provide Project Management support to the Board on the Exemplar Design and ERs. Generally, I had less involvement in the Children's Hospital (RHC) and more of my time was spent on the Adult Hospital (QEUH).

32 Exemplar Design is the use of a model, or example elements, to inform the creation of a new design. Exemplars are used to provide guidance, identify potential issues and to inspire new ideas. Project management of the Exemplar Design process brings together designers and stakeholders to facilitate sessions where the stakeholders can outline their requirements to the design team. Subsequent sessions involve reviewing draft design solutions until an agreed Exemplar Design for that specific department is agreed.

33 It should be noted that these Exemplar Designs were only a sample of key departments. From recollection Exemplar Designs were prepared for eleven departments, including Critical Care, A&E, imaging, an adult ward and a children's ward. These were departments and not wards, although some departments included wards. The completed Exemplar Designs were not integrated with each other.

34 The development of the Exemplar Design required a series of meetings between the Technical Team and the Board end users (clinical specialists connected with the chosen department) and stakeholders (such as Estates and Infection Control). I recall that these were large meetings and could involve as many as thirty people. The Board Project Managers for each hospital, Heather Griffin for the Adult

Hospital or Mhari McLeod for the Children's Hospital, invited the appropriate end users and stakeholders and so are better placed to comment on who was invited to attend the various meetings from these groups. My primary role was to facilitate the sessions where the end users and stakeholders were setting out what their requirements were (e.g. A&E needs to be close to imaging departments) and the designers were asking questions to understand that.

35 I would describe my role as facilitator to assist the end users and stakeholders in presenting their requirements to the designers and getting the designers to understand what the end users and stakeholders required. I was party to all the discussions, but I was not the designer, end user or stakeholder and my role was only to encourage work to progress.

36 I have been asked whether, in carrying out my role, I was aware of the design requirements of the Project. I was familiar with and was aware of the contents of the Employer's Requirements and the list of guidance documentation, however, as I am not a designer the technical content and application of the guidance was beyond my remit, experience, and understanding. Currie & Brown engaged and relied on the Technical Team to develop and review the clinical and technical aspects of the Employer's Requirements.

37 Producing an Exemplar Design is an iterative process and subsequent sessions involved reviewing draft design solutions until an agreed Exemplar Design for that specific department was agreed. My role at these subsequent sessions was the same. My role was primarily to organise and facilitate these sessions alongside the Board Project Managers, Heather Griffin and Mhairi McLeod, to ensure that the requirements were accurately represented by the outturn Exemplar Designs for the relevant departments.

38 The Clinical Output Specifications that were included within the ERs were produced by user groups which were typically led by the Board Project Manager

for the relevant hospital, i.e. Heather Griffin for the Adult Hospital and Mhari McLeod for the Children's Hospital. The relevant NHS guidance that was included in the ERs was primarily collated by Mark Baird of Currie & Brown and the Technical Team.

39 It is important to understand that, whilst the Exemplar Design was an important tool to inform the bidders in the Competitive Dialogue process, and therefore in selection of the successful bidder, it did not form any part of the final design and was never built. The final design was developed by Multiplex and its design team at further meetings/sessions with the full stakeholder group later, during the Design and Construction Phase (after the Contract was awarded to Multiplex). This process involved repeating the exercise for the 11 departments and completing the process across all departments (I believe there were circa 96 in total) with groups involving end users and stakeholders. I participated in a significant number of these meetings, mainly focussed on the adult hospital, but was not involved in all departments.

Removal of the Maximum Temperature Variant

40 I have been asked about my involvement and understanding, if any, in the removal of the maximum temperature variant. **(Bundle 17, Document No.26, Page 1063).** My expertise and role was restricted to Project Management activities and I am not a mechanical engineer. Therefore, I had no technical involvement in this and am not qualified to comment on this from a technical perspective. Room temperature guidance is typically set out at an early stage in ERs and was initially set at 28 degrees for the Project. Through facilitating Project meetings where technical matters were discussed, I was aware that Alex Macintyre, the Board Director of Facilities, had expressed concern about the maximum room temperature which was set at 28 degrees. I became aware from these same meetings that a new maximum room temperature of 26 degrees was then set, with a possible allowance of exceeding the maximum for up to 50 hours per year.

I cannot recall a specific meeting where the decision to adopt this new maximum room temperature was approved, or who made the decision. This is a question that Peter Moir would have been able to answer, although I am aware that sadly Peter is now seriously unwell so I appreciate it may not now be possible for that to be put to him.

41 I have been asked why Alex McIntyre was concerned about the maximum room temperature being set at 28 degrees. I recall that this was based on his experience of “lessons learned” in relation to patient comfort from previous projects such as ACADs at Victoria and Stobhill, i.e. that the rooms were found to be too warm and that this was also the rationale for reducing the maximum room temperature to 26 degrees.

42 I have been asked who from Currie & Brown was involved and what role they had in the technical aspects of this decision. Wallace Whittle in its capacity as mechanical engineer was involved in this as part of Currie & Brown’s Technical Team at this time. Currie & Brown did not itself have any separate involvement in the technical aspects of this decision as Currie & Brown did not have the required technical expertise and was instead relying on its consultant Wallace Whittle to advise on this.

Use of Chilled Beams

43 I have been asked about my involvement in and understanding of the decision to use chilled beams, if any. Similar to the position with the maximum temperature variant, my role was restricted to Project Management activities; as I am not a mechanical engineer I had no technical involvement in the plant selection and am not qualified to comment on this from a technical perspective. I cannot recall a specific meeting where the decision to use chilled beams was approved, or who made the decision. This is a question that Peter Moir would have known the answer to.

44 I have been asked who from Currie & Brown was involved and what role they had in the technical aspects of this decision. Again, Wallace Whittle as mechanical engineer was involved as part of Currie & Brown's Technical Team at this time. Currie & Brown had no separate involvement in the technical aspects of this decision due to its lack of technical expertise and relied instead on its consultant Wallace Whittle to advise on this.

45 I have been asked what risk assessments were taken prior to the decision to use chilled beams and what the impact of using chilled beams was. I am not aware of any risk assessments which may have been undertaken in relation to this decision as this was not part of my role. It was for Multiplex and its design team to undertake any required risk assessments. As I am not a mechanical engineer I do not know and therefore am not able to comment on the impact of using chilled beams.

46 I have been asked who provided the specification for environmental data relating to air change rates, pressure differentials and filter requirements. These specifications were included in the ERs and were provided by Wallace Whittle.

47 I have been asked who was responsible for HAI-SCRIBE assessment regarding the proposed site development, design and planning and new construction. The Board was responsible for this.

Technical Review Group Meetings

48 The Inquiry have directed me to minutes of the Technical Review Group meetings dated 30 January 2009 and 13 February 2009 (**Bundle 17, documents 42 and 43)**.

These were meetings of the Exemplar Design Technical Group. The purpose of those meetings was to pull together ER documentation that would eventually go out to the bidders for the Competitive Dialogue process. I would make the point that there were more than two meetings in this process.

49 My role in the Technical Review Group was purely to pull documentation together, I did not have any input into the actual technical content of the documents. Mark Baird of Currie & Brown took the lead in the compilation of the ERs, and I supported him with that task.

50 Compliance with the SHTMs and HTMs was extremely important and was a fundamental requirement of the ERs. I can see from both sets of the minutes to which I have been referred that SHTM/HTM compliance was listed as a separate agenda item which shows the significant weight attached to the issue. The reason why compliance was so important is because the SHTM/HTM was guidance developed and provided by the NHS and specialists in those fields and therefore it needed to be fully considered. I also believe it was a term of the Contract that the SHTM/HTMs were complied with. It is important to note that at this stage the group was putting the SHTMs and HTMs into the document alongside the exemplar department design layout which formed part of the Employer's Requirements.

51 I have been asked whose job it was to ensure that the significance of the SHTM was retained and locked into the Project prior to the Construction Contract being awarded. I consider that this was the responsibility of the Project team as a whole and recall that the SHTMs were incorporated into the contract documentation, including the ERs.

52 I have been asked whose job it was to ensure that BREEAM was not prioritised over SHTM. This would be the responsibility of the Board's Project Director as the BREEAM Advisor was appointed directly by the Board.

53 I have been asked whether the Technical Review Group discussed BREEAM and energy efficiency, what weight was placed on achieving BREEAM excellent status, and whether this was ever given priority over SHTM/HTM compliance. The ERs reflected the Board's requirement to achieve BREEAM excellent status, which I understand was a Board requirement for all of their capital projects (and may have emanated originally from the Scottish Government). This is not an unusual requirement and is pretty standard for public projects. This required a score of 70 points or more on the BREEAM scoring matrix and so the Project would aim to achieve more than that. My recollection is that BREEAM was never given more importance than SHTM/HTM compliance and in my experience, you would not decide to improve this score if it meant going against guidance in the SHTM.

54 Separate to BREEAM, the ERs also contained an energy target of 80kg of carbon per square metre, per annum. This target was set because of the importance of energy efficiency and reducing carbon emissions. I was aware that this target was in the ERs but was not at the meeting where this target was set. Stewart McKechnie of Wallace Whittle or Susan Logan of Ecoteric (the Board's sustainability consultant) would be better placed to respond to this question.

Competitive Dialogue – April 2009 to August 2009

55 As Lead Consultant Currie & Brown supported the Board in undertaking a competitive tender to secure a design and build contractor. A design and build contractor takes on the responsibility both for the design and construction of a facility. Currie & Brown was responsible for the project management of the Competitive Dialogue process. This is a procurement process that allows bidders

to submit initial solutions and then undertake a series of negotiations with the client to discuss and develop the solutions.

56 Currie & Brown's role involved ensuring that the sessions were administered correctly, and that all discussions were recorded in the action tracker. In practical terms this required Currie & Brown to ensure that the discussion sessions were held between the Board, including their end users and stakeholders, and the bidders on an individual basis. We ensured that each session was administered correctly, that each stayed confidential (e.g. that design features and details from one bid were not discussed in front of another bidder) and that all discussions were recorded in action trackers. I attended all the Competitive Dialogue sessions. My role was to support the organisation of the sessions and to facilitate break-out sessions focusing on clinical functionality and design.

57 Subsequent sessions involved the bidders presenting their developing designs in order to get feedback from stakeholders and user groups to further improve them for their final offer.

Selection of Sealed Building design

58 I have been asked about the impact of selecting a sealed building design, who approved the decision, and why this decision was made. To the best of my recollection, this was considered at the Competitive Dialogue stage. Whilst I facilitated meetings where I was aware discussions were being held about sealed building design, it was Alan Seabourne's responsibility as Project Director to obtain approval for the decision to select a sealed building. Any technical questions regarding the impact of selecting a sealed building design should be answered by a mechanical engineer as I was not there to provide technical input.

59 I have been asked what my understanding was of the rationale for this decision. My understanding from my attendance at the meetings referred to above was that the Board's rationale was to minimise risk of infection as well as reducing odour nuisance.

Bid evaluation – September 2009 to October 2009

60 Assessment of the bids took 3-4 weeks and involved a team of 30-40 people including representatives from the Technical Team, members of the Board Project Team such as Alan Seabourne, Peter Moir, Frances Wrath and Mhari McLeod, and Board nominated end users and stakeholders. The Board would be better placed to list all clinical end user and stakeholder attendees. The assessment was in two distinct areas, namely: (i) quality and (ii) commercial. During the process those scoring quality had no access to the commercial scoring, and vice versa, to ensure that neither element was influenced by the other.

61 The Technical Team, clinical end users and the Board Project Team were involved in the technical assessment. They would do the required reading and then get together and come to a consensus scoring. I was involved in the quality scoring area which was led by Peter Moir of the Board. Others were involved in the financial scoring. Only when the quality and commercial scores were finalised were they combined. Legal scoring was also independent and undertaken by Shepherd and Wedderburn, the Board's lawyers.

62 Throughout the bidding process, compliance with the ERs, which included SHTM/HTM compliance, was an important part of the assessment.

63 I have been asked whether SHTM compliance was regarded as being of paramount importance. I have also been asked what else was of paramount importance. SHTM compliance was considered extremely important, however, where the Board's requirements created conflicts with guidance, alternative

design solutions were developed and appraised. Patient safety and comfort were of paramount importance.

64 I have been asked how this importance was reflected in the scoring. I no longer have access to the bid scoring documentation and, as this was 16 years ago, I cannot recollect the scoring detail. This question would be better put to someone with access to the relevant documentation.

65 Presentations were made to the Board regarding outcome of the evaluation of the three bids submitted. Currie & Brown participated in the preparation of these presentations. Mark Baird and I were involved in collating the technical scoring and Douglas Ross was involved in separately reporting on the cost element. The presentations were led by Alan Seabourne, the Board Project Director, who presented a recommendation for a preferred bidder based upon the MEAT (Most Economically Advantageous Tender) scoring criteria. As I have no access to my files from the time (because I no longer work for Currie & Brown), I cannot recall the details of the scoring outcome, however the Multiplex bid was technically evaluated as “the most economically advantageous tender”, providing the Board with the best value for money. Quality and price formed part of the evaluation, with a weighting aimed at quality. I was present at some, but not all, of the presentations led by Alan Seabourne and Peter Moir. Douglas Ross presented on the cost elements of the sessions.

Ventilation Derogation

66 I have been asked to explain my understanding of the ventilation design strategy contained in the Contractor’s Tender Return Submission dated 11 September 2009 **(Bundle 18 Volume 1, Document 8, Page 205)**. I had no technical involvement in this, as I am not qualified to comment on this from a technical perspective (not being a mechanical engineer, as mentioned above). Whilst I facilitated meetings where I was aware discussions were being held about the ventilation design

strategy, it was Alan Seabourne's responsibility as Project Director to seek support for any decisions in respect of the ventilation design strategy. Any technical questions regarding the ventilation design strategy should be answered by a mechanical engineer as I was not there to provide technical input.

67 I have been asked who provided technical support from Currie & Brown during the discussions about the ventilation design strategy. Because it had no technical expertise of its own, Currie & Brown sought advice and input from its consultant Wallace Whittle, the mechanical engineers in Currie & Brown's Technical Team at the time. Currie & Brown were reliant on Wallace Whittle for this technical input.

68 I have been asked whether it was part of my role to ensure the importance of SHTM was stressed and to ensure that there was a process to inform the Board of any significant departure from SHTM. This was part of my role in providing project management support to the Board. As referred to at paragraph 63 above, SHTM compliance was considered extremely important and it was stressed by me and by members of Currie & Brown's Technical Team, including in the Employer's Requirements and during discussions about any proposed departures from SHTM. The clarification logs were the tool to communicate any potential departure from SHTM and record decisions made. The logs were understood by the Board, and by all on the Project, to be the correct channel for communications on such issues. This is because this is the standard practice on projects of this nature - this is not unusual at all. Post award of Building Contract, responsibility for informing the Board of any significant departure lay with Multiplex as designer.

69 I have been asked whether the design and/or specification of the ventilation system as recorded in the Building Contract, in particular in the M&E Clarification Log (**Bundle 16, Document No. 23, Page 166)**, was compliant with NHS Guidance and if not, why this design was designed, proposed and accepted. As before, because I am not a mechanical engineer, I had no technical involvement in this and so am not qualified to comment on this from a technical perspective. Whilst I

facilitated meetings where I was aware discussions were being held about the design and specification of the ventilation system; it was Alan Seabourne's responsibility as Project Director to seek support for any decisions in respect of the design and/or specification of the ventilation system. Any technical questions regarding the ventilation system should be answered by a mechanical engineer as I was not there to provide technical input.

70 I have been referred to the **Design Summary document (Bundle 43 Volume 2 Document 21)** The Inquiry have referred me to the 'Brookfield Comment' section at page 5 of this document which states: 'Brookfield proposal as outlined within the bid submission is to incorporate chilled beams as a low energy solution to control the environment which do not rely on large volumes of treated air or variable natural ventilation. All accommodation is single bedrooms and therefore the need for dilution of airborne microbiological contamination should be reduced (rooms could also be at slightly negative pressure to corridor). Providing 6 air changes is energy intensive and not necessary.' I have also been referred to the comment in the far right hand column of this document by John Bushfield of Wallace Whittle which states: 'This derogation to the SHTM is not accepted. Any variation would require Board clinical infection control review.'

71 I have been asked what concerns, if any, I had regarding non-compliance with SHTM and whether this was the first time that non-compliance with SHTM was brough to my attention in respect of ventilation. I have also been asked what action, if any, I took to obtain Board clinical infection control review, and how given John Bushfield's comments this derogation came to be accepted.

72 The document I have been referred to is an appendix to the ERs in the Contract. Not being a mechanical engineer, I had no technical or direct involvement in this and am not qualified to comment on this from a technical perspective. I was at Project meetings where the potential derogation from the SHTM was discussed. My recollection is that following the comments referred to above by John Bushfield, a report was produced by Wallace Whittle which discussed compliance

with the Chartered Institution of Building Services Engineers (CIBSE) design standards however I did not see this report at the time and do not have a copy of it. I recall discussion that the Wallace Whittle report was based on 5 people being present in the room: the patient, two members of the patient's family, a doctor and a nurse. I had no involvement in organising IPC review on the proposed derogation, but there was an IPC Nurse, who I think was initially Annete Rankin, until she was replaced by Jackie Sewart, on the Project Team. I recall being in a meeting where people were reporting back that there had been discussions with IPC on the issue.

73 I have been asked whether it was part of my role to ensure the importance of SHTM was stressed and to ensure that there was a process to inform the board of any significant departure from SHTM. As I refer to at paragraph 68 above, the clarification logs were the tool to communicate such issues and record decisions made.

I have been asked when I first became aware of the agreed ventilation derogation recorded in the M&E Clarification Log (**Bundle 16, Document No. 23, Page 1662)**. From recollection, this formed part of the Multiplex bid and was discussed in the period up to contract execution in December 2009. The Design Summary Document **(Bundle 43 Volume 2-Procurement Contract Design and Construction Miscellaneous document 21)** was referred to Wallace Whittle by Currie & Brown for comment and discussed with the Board. Mark Baird, who managed the Clarification Log, led organised these discussions, arranging for the engineers to attend as requested by the Board, for example on Currie & Brown's behalf. I may have been present at some, but not all, of these discussions and do not recall the detail. I have been asked what concerns, if any, I had regarding the derogation. As part of the team reviewing the position, we were aware that the alternative design solution did not achieve 6ACH and this was why the design was referred to Wallace Whittle for advice. I recall Alan Seabourne telling me he

had, in addition, made contact with Peter Hoffman of Public Health England to seek advice on the issue of ventilation generally.

74 I have been asked whether I am aware what advice Alan Seabourne received from Peter Hoffman on the issue of ventilation and whether Alan asked Mr Hoffman about the proposed ventilation derogation. I am not aware of the detail of the conversation, however I understand that Peter Hoffman confirmed that the air change requirements related primarily to patient comfort. For fuller understanding, this question would be better put to Alan Seabourne and Peter Hoffman.

75 I have been asked what my understanding was of the advice received from Wallace Whittle regarding the impact of non-compliance. My understanding from discussions with the wider team was that Wallace Whittle advised that the alternative design was in line with CIBSE good practice, considering an occupancy of 5 persons in the single bedroom.

ZBP Ventilation Strategy Paper

77 I have been asked when I first became aware of the ZBP Ventilation Strategy paper dated on or around 15 December 2009 (**Bundle 16, Document No.21, Page 1657)**. I note that this document was sent by email from Ross Ballingall of Multiplex to Mark Baird at 08:16 on 15 December 2009 (**Bundle 17, Document No.72, Page 2863)**. I was also named as a recipient on this email, however as the email was addressed to Mark, it is likely that I was effectively copied into the email to be able to progress matters if Mark was unavailable. This was likely to be the first time I became aware of this document. Ongoing consideration of final matters relating to the contract were discussed in December 2009 and this document was, to the best of my recollection, issued at around this time.

78 I have been asked why advice was sought from Wallace Whittle on the ZBP Ventilation Strategy paper, from whom advice was sought, and what was their opinion of the document. I have also been referred to a number of emails between Mark Baird and Stewart McKechnie of Wallace Whittle over 15 and 16 December 2009 **(Bundle 16, Document No.21, Page 2861)** regarding the ZBP Ventilation strategy document which I have been asked to comment on. As I was not involved in all of these emails, and was likely to have been copied into some for information purposes only, Mark Baird would be better placed than me to comment on this.

79 I was aware of discussions about this only at a general level from my attendance at Project Team Meetings but was not directly involved and was not asked to provide any technical input or advice as I was not qualified to do so. I do not recall seeing any calculations from Wallace Whittle on this issue.

80 I have been asked whether the ZBP Ventilation Strategy paper was escalated to the Board and if so, what action was taken in response. I do not recall being aware of this paper at the time and consider that Mark Baird or Stewart McKechnie would be better placed to comment on this in view of their direct involvement.

81 I have been referred to an email exchange between Mark Baird and Stewart McKechnie of Wallace Whittle dated 15 December 2009 **(Bundle 17, Document No.72, Page 2861)**. I was only copied into part of this email exchange; I was copied into Mark Baird's email to Stewart McKechnie at 08:41 **(Bundle 17, Document No.72, Page 2869)** but do not appear to have been copied into Stewart McKechnie's reply to Mark Baird at 10:04. My inclusion was likely to have been for awareness and not for action or my specific attention i.e. to allow me to pick up the issue if Mark was unavailable or similar. Mark Baird or Stewart McKechnie would be best placed to comment on the purpose of the review and how much reliance was to be placed on the review. As I was not directly involved in the exchange, or in the review undertaken by Wallace Whittle, I cannot comment on the scope of their review.

82 I have been asked how important achieving BREEAM targets was in considering the ZBP ventilation strategy. As I was not directly involved in the email exchange with Wallace Whittle, or Wallace Whittle's review of the ZBP Ventilation Strategy, I do not have first-hand knowledge of this issue. The Board retained a BREEAM advisor, Susan Logan of Ecocentric, and she may be better placed to answer any questions regarding BREEAM.

83 I have been asked whether the ZBP Ventilation strategy was compliant with SHTM, and if not what the justification was for departing from national guidance. I would defer to Stewart McKechnie of Wallace Whittle's email to Mark Baird of 10:04 on 15 December 2009 (**Bundle 17, Document No.72, Page 2863**) on the issue of compliance, as I am not technically qualified to comment on this. In terms of the justification for departing from guidance, in any complex design there are conflicting requirements and the guidance acknowledges this. Any acceptance of change to ERs had to be made by the NEC Project Manager, Peter Moir. Any Alternative Design Solutions were reviewed and assessed by Stakeholders and where necessary by either the NEC3 Supervisor or the exemplar design team, by individual instruction.

84 I have been asked what risk assessments were carried out, if any, in respect of the proposal and who was responsible for ensuring that appropriate risk assessments were carried out. Risk assessments were responsibility of the Board, and it would be IPC who would undertake those risk assessments on behalf of the Board. Currie & Brown had no responsibility for risk assessments, and I was never asked to produce one. Therefore, I am not aware of any specific risk assessment that may have been carried out. Contractually, the proposal for reduced air changes was accepted by the Board as NEC3 Project Manager. I understand that in carrying out the review of this Alternative Design solution, Board infection control staff, including those on the Project team, were consulted. External advice on the purpose of air change rates (comfort or infection control)

was also sought by the Board from Peter Hoffman. I am aware either through discussions with Alan Seabourne at the time, or through discussions in meetings which I attended where people were reporting back on activities undertaken, that Alan Seabourne and Peter Moir were involved in the discussions with Peter Hoffman and Board IPC staff.

85 I have been asked what my understanding was, at the time, of which wards and rooms the proposal was intended to be applied to and which wards and rooms it was in fact applied to. The discussions around reduction related to the adult general wards where there were single rooms and SHTM requirement for 6 air changes. At that time the proposal was for single rooms in general wards only. At the point of my departure from the Project and Currie & Brown, I was unaware that this was applied to other areas.

86 I have been asked whether I can refer the Inquiry to any documents to support my understanding above. As I left my employment with Currie & Brown in February 2016 and have not subsequently had access to any files, I am unable to provide the Inquiry with or refer to any documents.

87 I have been asked whether in carrying out the review of the ZBP Ventilation Strategy, Board Infection Prevention and Control (IPC) team/staff were consulted. As Wallace Whittle carried out the review, I am unable to comment on this and believe that Wallace Whittle would be better placed to comment.

88 I have been asked whether I am aware of any risk assessments, whether in compliance with the standards in HAI Scribe or otherwise, that the Board carried out in respect of the change in the ventilation strategy that appears to follow the ZBP Ventilation Strategy Paper. As above, Currie & Brown had no involvement in carrying out any risk assessments and I am not aware of whether any risk assessment was produced. Any risk assessment would presumably have been undertaken by Infection Control on behalf of the Board. The Board were

responsible for instructing Infection Control or external experts, unless Currie & Brown was specifically asked by the Board to do something. In this instance, we were not asked to undertake that work. This question is therefore better posed to Alan Seabourne.

89 I have been referred to an email exchange between Mark Baird and Stewart McKechnie of Wallace Whittle dated 16 December 2009 (**Bundle 17, Document No.72, Page 2869)**. I was only copied into part of this email exchange; I was copied into Mark Baird's email to Stewart McKechnie at 08:51 which sets out a number of issues for discussion, including "Air Changes – WW to take Board through this + specific query = do we think SHTM 03-01 is driven by temperature or HAI for stated nr oa air changes". I do not appear to have been copied into Stewart McKechnie's reply to Mark Baird at 09:08. Again, my inclusion was likely to have been for awareness and not for action or my specific attention, i.e. to allow me to pick up the issue if Mark was unavailable or similar. I cannot recall if I attended the meeting in question and so any queries in relation to whether Wallace Whittle advised the Board regarding proposed air changes on the M&E Log at the time, and details surrounding that would be better asked to Mark Baird, Stewart McKechnie, or one of the others who were in attendance.

90 I have been asked by the Inquiry whether, given my recognition of the importance of SHTM, it was part of my role to ensure that "if the Board was going to build hundreds of single rooms in a flagship hospital without complying with national and UK guidance this was fully understood and assessed". In my project management support role I was part of making sure that the Board Project team, including senior members such as Peter Moir and Alan Seabourne, were fully aware of the proposed alternative design solution via provision of information and meetings on the subject matter both pre and post signing of the contract. As explained in more detail in paragraphs 66 to 76 above, I fulfilled that role by supporting my colleague Mark Baird in facilitating discussions of the proposed alternative design solution in meetings with Wallace Whittle, who had the

appropriate technical expertise to advise; and by ensuring the proposed derogation that came out of those discussions was recorded in the appropriate clarification logs in line with agreed and standard practice.

91 I have been referred to a further email exchange between Mark Baird and Stewart McKechnie of Wallace Whittle timed at 18:44 on 16 December 2009 **(Bundle 17, Document No.72, Page 2869)** which states “Think we have a way forward on this one, need a calculation carried out however tomorrow morning to prove our resolution. This involves litres per second, air changes etc and therefore requires your technical input and illustration. Can we have support for half-hour/hour in the morning please”. Again, my inclusion on this email was likely to have been for awareness and not for action or my specific attention. I do not think I attended the meeting the following morning and I was not party to or involved in the resolution that was being discussed so cannot comment in respect of this and suggest that Mark Baird or Stewart McKechnie may be better placed to comment.

92 I have been told that the Inquiry is aware of several departures from SHTM 03-01 Guidance in relation to air change rates, pressure differentials and filtration requirements as well as a variation to the primary extract arrangement for PPVL isolation rooms from that set out in SHPN 04 Supplement 01. I have been asked whether Currie & Brown was aware at the time of these non-compliances and if so, how Currie & Brown communicated these non-compliances to the Board Project Team. I was not aware of this or involved in this at the time. The responsibility for compliance with the ERs and in turn the guidance was fully with Multiplex and any variance should have been highlighted by Multiplex to the Board Project Manager via an Early Warning Notice. Where this occurred, the process was for the Board to appoint a qualified reviewer, typically the NEC Supervisor (i.e., Capita), to comment upon the alternative design. The NEC Supervisor was also responsible for checking that the construction was compliant with the design.

93 I have been asked whether I recall Capita checking whether construction was compliant with the design and, if this was not being carried out by Capita, whether I escalated this as an issue. It was not any part of my role or Currie & Brown's role to check Capita's work, and we did not have full visibility of their work (nor were we expected to) – it was for the Board, who appointed Capita, to manage Capita's work. Currie & Brown had no responsibility or authority to check Capita's work. I was generally aware from my attendance at meetings that Capita was undertaking checks on both construction and system installation. The Capita contract was managed by Peter Moir of the Board, not by Currie & Brown. I personally was not aware of any failings in Capita's service delivery.

94 I have been asked what material including drawings was necessary to allow Capita to check compliance. The full suite of design documentation was available to Capita via Multiplex's document management system Aconex. As above, it was not part of my role or Currie & Brown's role to manage Capita, and we had no authority to do so, so I do not know what documents Capita did or did not review. This is a question that would be better directed to the Board (who appointed and managed Capita), or to Multiplex (who managed the issuance of project documentation), or to Capita itself.

95 I have been asked whether the Ventilation Derogation noted in the M&E Clarification Log was recorded in the Full Business Case. I don't know and therefore cannot comment on this as I was not directly involved in the preparation of the Full Business case. This was a Board activity and therefore this would be better directed to the Board.

96 I have been asked how the agreed Ventilation derogation was signed off by the Board and asked about my personal knowledge of the comments in Currie & Brown's response to PPP13 that the Board Project Team advised Helen Byrne and Alex McIntyre (Director of Facilities) and Peter Gallagher (Director of Finance) of the agreed ventilation derogation. I do not know if there was ever a formal document that was signed by any senior members of the Board but I was aware

at the time that Alan Seabourne and Peter Moir had advised these senior members of the Board. I recall that Helen Byrne was Alan Seabourne's line manager and believe that Peter Gallagher was from the Board's finance team. My understanding is anecdotal however, and I cannot remember how I came to have that knowledge.

Design and Construction phase 2010-2015

97 From 2010-2015 the Project moved to the design and construction stage. There were two elements of work which were contracted out. Firstly, the Laboratory where Multiplex moved straight onto construction. Secondly, the hospitals which went into a 12-month period of design before Multiplex was awarded the Contract in 2010.

98 Once Multiplex was appointed as Design & Build Contractor in 2010, the Board assumed the formal role of NEC Project Manager. As NEC Project Manager, the Board was responsible for the impartial administration of the contract including but not limited to responsibilities for:

98.1 Time and cost management.

98.2 Risk management.

98.3 Contract administration.

98.4 Compensation events.

98.5 Record keeping.

98.6 Early warning.

98.7 Project delivery.

99 At this point, the Board established a series of Project Groups as part of its Project governance. I was appointed as a member of the following groups:

99.1 Project Steering Group, whose remit was to identify and review strategic drivers for the Project, review Project issues reported from sub-groups, monitor and identify any shortfalls in Project resources, and monitor the critical path of the Project programme. Both Alan Seabourne and Peter Moir were also in this group.

99.2 Project Management Group, whose remit was to monitor change control, the construction and design programme, Project administration, oversee the work and sign-off proposals of sub-groups, unblocking any issues and monitor community benefit programmes. Both Alan Seabourne and Peter Moir were also in this group.

99.3 Technical Design Group, which had a focus on planning applications and conditions as well as monitoring compliance with the ERs and CPs and managing any derogations or clarifications to either. Both Alan Seabourne and Peter Moir were also in this group, along with Board Infection Control.

99.4 Design and Healthy Environment Strategy Group, which was a sub- group of the Technical Design Group focused on how art could be best incorporated into the Project and to agree the Project Art Strategy. Peter Moir was also in this group.

99.5 Medical Planning Group, whose remit was to monitor the medical planning programme, the medical planning sign-off process, manage mock-ups for functionality sign-off and monitor production of the RDS. Alan Seabourne and Board Infection Control were also in this group.

100 My role on these groups was to provide project management support to Peter Moir or Alan Seabourne.

RDD process

101 I have been asked about my involvement in the Reviewable Design Data (RDD) process and User Group Meetings. I was in attendance at a significant number of User Group Meetings in support of the Board Project Manager, primarily for the Adult Hospital. My role in these meetings was to understand the aims of both parties and facilitate discussion to agree the way forward. In this role I was also involved in the RDD process which was where Multiplex submitted their proposals for comment by the Board. It is important to note that this was limited to clinical functionality (i.e., end user clinical requirements ensuring that the right things were in the room, e.g. sink, bed, medical gases etc.) and this did not involve setting or commenting on the technical specifications, or technical compliance. Technical compliance for the design was always the responsibility of Multiplex, as set out in the ERs.

102 In accordance with the sign off process for drawings and Room Data Sheets, this information was shared with Currie & Brown via Multiplex's Aconex document management system. Currie & Brown and the NHS Project Team had access to RDD documentation via Aconex as did Multiplex and their supply chain and Capita as NEC Supervisor. The decisions agreed at the User Group Meetings were communicated via design documentation revision on Aconex. Currie & Brown's role was to check compliance with clinical functionality and my role in this

was to review changes against meeting notes, revert to end users where necessary and sign-off on behalf of the Board.

103 I have been asked how the technical requirements (air change rates, pressure differentials and filter requirements) for the rooms were managed and approved and to describe my role and involvement in that. In accordance with the NEC Contract, Multiplex were responsible for technical compliance with the ERs including SHTM/HTM compliance. Any alternative design solutions had to be highlighted and approved. I had a Project Management co-ordinating role in this process. If Multiplex came up with a proposal which wasn't exactly in line with the guidance then it was referred to an appropriate person in terms of design e.g. Peter Moir instructed Capita to undertake some design review work on elements of the ventilation systems. I had to counter-sign some drawings but only for clinical functionality where they had been reviewed by User Groups and they were content with them, or where a designer had reviewed the proposal and signed it off to say that they had been reviewed, because Multiplex would not recognise a Capita signature. As far as Multiplex were concerned, they wanted to see one of 3 or 4 names on the drawing e.g. Peter Moir, Frances Wrath or me. I signed off that the process for reviewing the design had been completed, not the technical design itself.

104 I have been asked why Multiplex did not recognise a Capita signature. The process for sign off was put in place early in the design development stage, before Capita was appointed as NEC Supervisor, so Capita was not included in that process. My understanding is that, as a result, Multiplex requested a counter signatory. However, this is a matter that Multiplex or Capita would be better placed to comment on.

105 I have been asked whether it was part of the reviewing design process to ensure that the design complied with guidance and whether this is what I was signing off on. Compliance with guidance was fully the responsibility of Multiplex and its

design team, and this is not what I was signing off on. Neither I nor Currie & Brown was expected to sign off on compliance with guidance because this was not part of our role, as all participants in the Project knew. I was not qualified to sign off on compliance with guidance anyway. It was the Board's responsibility to check clinical functionality.

106 I have been asked what design work Peter Moir instructed Capita to undertake on elements of the ventilation systems. I did not ever see these instructions as they were direct from the Board to Capita. To be clear, Currie & Brown had no responsibility at all for the management of Capita which fell entirely to the Board, who had appointed Capita. The extent of the instructions would need to be checked and advised by someone with access to the historic contract administration documents which will include any compensation events issued to Capita under their appointment. I do not have access to those documents, having left Currie & Brown in 2016.

107 I have been asked to describe the intended use and purpose of the following wards in QEUH/RHC: Ward 4B – QEUH; Ward 4C – QEUH; Level 5 – QEUH; Critical Care – QEUH; Ward 2A & 2B – RHC; PICU RHC – RHC; all Isolation rooms. I don't have access to all my files to check all wards, but my recollection is Critical Care was the Critical Care Ward, PICU was the Paediatric Intensive Care Unit and my understanding was that Ward 2A/B were intended to be used as the Paediatric-Oncology Unit which includes the Teenage Cancer Trust and the paediatric Bone Marrow Transplant (BMT) Unit.

108 I have been asked what guidance was considered in the design of these wards and what processes were in place to ensure guidance compliance. The guidance was the relevant SHTM or HTM requirements as set out in the ERs. Multiplex was responsible for technical compliance with the ERs. The NEC Supervisor was responsible for witnessing and accepting the facilities and ensuring that what had been built complied with the ERs. Capita would be better placed to comment on compliance in view of their role.

109 I have been asked whether there were any changes to the design of Ward 4B – QEUH; Ward 4C – QEUH; Level 5 – QEUH; Critical Care – QEUH; Ward 2A & 2B – RHC; PICU RHC – RHC and all Isolation rooms during the design and build. This is a very wide question, and I have been unsure how to best tackle it. I have done my best to set out answers to more specific questions below.

110 I have been asked about my involvement in and understanding of the decision to remove carbon filters. I have been referred to the Board Project Manager Instruction #945 dated 26 April 2012 **(Bundle 43, volume 1, Document No. 44, Page 229)** which confirms the Board's decision to remove carbon filters. I was party to Project Team discussions where the issue of carbon filters was discussed. My recollection is that the carbon filters were considered to be onerous to maintain from an operational perspective and energy intensive to run as they created a large resistance to air movement. I understand that the Board decided to omit carbon filters on the basis that they were primarily included for odour management related to the adjacent sewerage treatment plant, and Scottish Water had a requirement/commitment to undertake improvement works to substantially improve the odour emission issues.

111 I have been asked what the understanding I have explained in the paragraph above is based on. This is based on my recollection of discussions on this matter in regular Project team meetings.

Ward 4B and 4C

112 I have been asked how the change in use of Ward 4B following a Change Order Request issued by the Board in July 2013 **(Bundle 16, Document No.29, Page 1699)** was communicated to Currie & Brown and how this change was captured

in the revised design and specification documentation. I was not directly involved in this change. I was aware of the changes via attendance at weekly risk reduction meetings but that was the extent of my knowledge/involvement. Peter Moir would have known the answer to this question.

113 I have been asked why suspended ceilings were installed in Ward 4B given that the Clinical Output Specification (COS) **(Bundle 16, Document No.15, Page 1595)** referred to 'space sealed' and whether Currie & Brown raised this as a non-compliance with the "works information". Multiplex was responsible for the design and construction in accordance with the ERs as modified/updated. Identifying non-compliances with Works Information was the responsibility of the NEC Supervisor, Capita. Similarly, during the construction phase Currie & Brown was not responsible for inspections and so I was unaware of this at the time and am unable to comment as to whether suspended ceilings were highlighted as noncompliant as works progressed. Without access to my files and records I am unable to confirm who approved the reflected ceiling plans for this area. I only became aware many years later, towards the end of my time on the Project, that an issue with suspended ceilings had been raised after handover.

114 In respect of Ward 4C's specification at the point of the Change Order and the justification for departing from the SHTM guidance in respect of ventilation, I cannot provide comment as I was not directly involved and had no more than a general and limited awareness of this at the time from my attendance at Project Team meetings. The Board's Assistant Project Director, Peter Moir, led on this. The same applies in respect of the requisite air change rate required with SHTM guidance in respect of Ward 4B and 4C and whether this was achieved. Peter Moir would have known the answer to this question.

115 I have been asked what role Currie & Brown played at Project meetings. These meetings covered a multitude of topics and individual attendees would provide updates on their assigned activities. This generally allowed all parties to have an

overview of what everyone was doing but not to go into the details of others' activities. My role was to report on the activities that I was involved in.

Wards 2A and 2B

116 I have been asked what my understanding was of the intended use and purpose of Wards 2A/2B, what guidance was considered in the design of these wards, and what processes Currie & Brown put in place to ensure compliance with guidance. My understanding was that these wards were intended to be used as the Paediatric-Oncology Unit which includes the Teenage Cancer Trust and the paediatric Bone Marrow Transplant (BMT) Unit. The guidance was the relevant SHTM or HTM requirements as set out in the ERs. Multiplex was responsible for all aspects of technical design/compliance for these wards. I recall that there were some specific end user requirements that required design adaption. I was informed by Mhari McLeod and Frances Wrath that there was a lot of discussion involving the clinicians for this department wanting the new department to mirror what they had at Yorkhill in terms of pressure differentials. I learned of these changes indirectly as I had a lesser involvement in the Children's Hospital and Mhari McLeod and Frances Wrath were primarily involved. I was in team meetings where some of this was discussed and talked through by Peter Moir and Frances and Mhari.

117 I have been asked what information Capita would have needed to ensure that these wards met what the ERs required and what the clinicians wanted. Capita had access to all of the design information prepared by the Multiplex design team and should have used this to assess compliance with the design. I do not know whether Capita did so – as stated above, neither I nor Currie & Brown had any responsibility for checking Capita's work or indeed any authority to do so. This is a question that would be better directed to the Board, Multiplex, or Capita.

118 I have been asked what changes, if any, were made to the design of these wards during construction, what impact any changes had to compliance with guidance and to describe the sign-off process for any such changes. The responsibility for compliance with the ERs and in turn the guidance was fully with Multiplex and any variance should have been highlighted by Multiplex to the Board Project Manager via an Early Warning Notice. Where this occurred the Board would appoint a qualified reviewer, typically the NEC Supervisor (i.e. Capita), to comment upon the alternative design. The NEC Supervisor was also responsible for checking that the construction was compliant with the design.

119 I recall that Capita was instructed via a Compensation Event Notice to review various alternative design drawings, including ventilation drawings. This was an additional service and involved an additional cost as Capita's primary role as NEC Supervisor was only to check what had been built, not to check any alternative design proposals submitted by Multiplex. Once the drawings had been checked and signed by Alan Follet of Capita, they were returned to Multiplex. However, Multiplex would not recognise Capita approval as authority to proceed and I therefore counter-signed some drawings to evidence the fact that they had been through the appropriate process. I was not signing off the technical content of these drawings as I was not qualified to do so.

120 I have been asked whether, in signing drawings, I was giving authority to Multiplex to proceed and whether this was within Currie & Brown's remit. I was countersigning these drawings only to confirm that they had been through a review process by Capita. The status of the drawings was advised by Capita following its review. Limited authority to sign drawings which required clinical functionality review only, or to counter-sign drawings which involved alternative design solutions, was delegated to me by the NEC Project Manager. Where alternative design solutions were proposed, as in this instance, authority to sign the drawing and allocate a status was delegated by the NEC Project Manager to

Capita, as Capita was qualified to review the technical content (whereas Currie & Brown was not).

121 I have been asked whether, with the benefit of hindsight, counter-signing drawings is something which I should have been expected to do given that I was not signing off the technical content. As above, I was counter-signing only to confirm that the drawings had been through a review process by Capita as per the authority delegated by the NEC Project Manager. The basis on which I was counter-signing drawings was well known by and clear to the Board, Multiplex, and Capita.

122 I have been asked to describe the IPC involvement in the design of Wards 2A and 2B. I recall the Board appointed an infection control nurse to the core client team across the Project from the outset and my understanding was this was to provide a direct and continuous link back to the wider Board Infection Control team. I am not qualified to comment on the qualifications or experience of these individuals. Given my limited involvement in this aspect, I was not aware of any concerns at the time regarding the final specification of Ward 2A and 2B.

123 I have been asked about my understanding of the requisite air change rate required in accordance with SHTM guidance in respect of Ward 2A and 2B, and whether this the air change rate was achieved. My understanding of the requisite air change rate required in accordance with the SHTM guidance for these wards was that they were specialist areas with specific requirements as set out in the SHTM/HTM. The actual rates achieved should have been measured during commissioning. I was unaware at the time of whether this air change rate was achieved. Multiplex was responsible for the commissioning. Capita was responsible for witnessing the commissioning for acceptance. I did not become aware until about two or three years after handover that these air change rates were not being achieved, around the time that external consultants were engaged to re-design the system. I am not aware of why those air change rates were not achieved.

Isolation Rooms

124 I have been asked how the number and location of Isolation rooms was agreed and approved, who was responsible for producing the drawings and specification for these rooms and who within the Project Team approved them. The number and location of the isolation rooms was a matter for the Board. My understanding was that the original intent was that each ward would have an isolation room, but that (with the exception of the critical care units) these isolation rooms were omitted by the Board following a debate within the Board about how many were needed. I was aware of that debate going back to 2009, but was not involved in it – it was a matter for Board and in particular Heather Griffin, Mhairi Macleod, and IPC. Multiplex was responsible for producing the room drawings and specifications. The Board Project Team was required only to approve the clinical functionality of them as per the contract.

125 I have been referred to the excel Room Data Sheets (RDS) and in particular a note under 'Design Notes' relating to Ward 2A isolation rooms which states: "WARNING NOTICE: This room is based on a theoretical design model; which has not been validated (see paragraph 1.8 of HBN 4 Supplement 1). Specialist advice should be sought on its design. The lamp repeat call from the bedroom is situated over the door outside the room." I have no personal knowledge of whether this note was entered on the RDS and if so by whom and when. I have been asked what specialist advice was sought regarding the design of these rooms. I do not know what specialist advice was sought or obtained, if any. This was a responsibility for Multiplex. They will also be best placed to confirm what the final agreed design was and who approved it. I was not in the meetings where the RDS were discussed and did not know the detail.

126 I have been asked why the main extract was placed in the patient's bedroom and not the ensuite as outlined in SHPN 04 Supplement 01. I have also been asked

why this change was requested, who requested it and who approved the change from the Project Team. I recall that the change was requested by Multiplex and their design team on the basis that it was thought to be a better solution than SHPN 04 Supplement 01. I had a general awareness of this decision from attendance at the Project Team meetings but was not directly involved and was not consulted on it, so am unable to recall this decision in detail. I presume Peter Moir approved as Project Manager in accordance with the processes required by the contract.

127 I have been asked to explain what I mean by “better solution” in the paragraph above. My understanding from discussions with Peter Moir was that this was to do with improved distribution of air, avoiding stagnant areas.

128 I have been asked what my understanding was of whether a risk assessment was carried out in respect of this decision given my awareness and attendance at Project Team meetings. A design evaluation was undertaken by Capita. I am not aware of a specific risk assessment. Risk assessment was a matter for the Board as they would engage with clinicians and infection control.

129 I have been asked whether I recall whether Peter Moir approved the decision. I do recall this to be the case.

130 The Inquiry has referred me to **Bundle 47 Volume 8 document 13 pg 16S** and **Bundle 47 Volume 8 Document 12 page 15**. I have been asked to describe my involvement in respect of the decision for the main extract to be placed in the patient bedrooms. As noted previously, I countersigned this drawing only to confirm it had been through a review process by Capita, I was not party to the design review discussions.

131 I have been asked to confirm what the amendment was. As I am not qualified to comment on matters of technical design, this question would be better put to the technical reviewer, Allan Follet.

Horne Taps

132 I have been asked to comment on my involvement, if any, in respect of the decision to use Horne taps. At the time of selection, I attended a specific focus group on the tap selection due to issues that had arisen in other hospitals around infection control and ease of access to filters. Board facilities staff, such as Ian Powrie, were also involved in this group and were part of the selection process as were Alan Seabourne and Peter Moir.

133 At this point in time, advice was sought by the Board Project Team from others within NHS as to the best practice in terms of tap selection. Specifically I am aware that Alan Seabourne engaged with the Director of Facilities at NHS Lanarkshire, David Browning, who had encountered some issues with water quality and recommended the use of the Horne tap. The general view was that the Horne tap was most easily maintained. The Project Team were involved in the selection including Project Director, Assistant Project Director and Facilities representative. As explained above, Currie & Brown had no responsibility for or involvement in risk assessments. Therefore, I was not involved in risk assessing the Horne Tap and cannot recall whether the use of them depended on thermal disinfection.

134 In follow-up questions from the Inquiry I have been asked whether I meant David Louden instead of Alan Seabourne in the paragraph above. I recollect that this was prior to Alan Seabourne leaving, and so recall it was Alan Seabourne.

135 I have been asked if I attended a meeting regarding the Horne Taps in 2014. I am unsure which meeting is being referred to. If it is the meeting with Health Protection Scotland held on 5 June 2014 **(Inquiry Bundle 15, Document 9, page 692)**, I was not in attendance (and nor was anyone else from Currie & Brown) but was aware that the meeting was taking place and learned of the outcome from Alan Seabourne or possibly David Loudon. I understood from my discussion with Alan or David that the outcome of the meeting was that, as the taps were already installed, they should be treated as existing and remain in place.

136 The Inquiry has asked me whether thermal disinfection was mentioned at the meeting on 5 June 2014. As I explained in the paragraph above, I was not at the meeting so do not know if thermal disinfection was mentioned then. Looking at the timing of this meeting I now think it was probably David Loudon who attended rather than Alan Seabourne. I cannot recall if thermal disinfection was mentioned in my discussion with David following the meeting.

Water System

137 I have been asked if I was aware of the water system being filled prior to handover on 26 January 2015. I was not aware of when the water system was filled. The water system would have had to be filled in time for handover, but I do not know when that took place and was not involved in the inspection, testing or witnessing of the water systems so cannot comment.

138 I have been asked to explain my understanding of why the water system had to be filled prior to handover, and my understanding of whether it should have remained full. I have been asked to explain my answer within the confines of my knowledge, understanding and experience. I do not have any technical understanding of this, but from my experience on other projects I understand that the systems would have had to be filled prior to handover so that they could be

flushed, tested and sampled. My understanding is that the system would remain filled and be flushed to a programme to maintain cleanliness.

Commissioning and validation

139 I have been asked what Currie & Brown's responsibilities and involvement were, if any, in respect of commissioning activities in relation to the ventilation system and water system. Currie & Brown was not involved in the commissioning of the water or ventilation systems. Commissioning was the responsibility of Multiplex with the NEC Supervisor, Capita, responsible for witnessing and notifying the NEC Project Manager.

140 I have been asked what support Currie & Brown provided to the Board in discharging its Project Manager functions. Assuming this query is referring to duties in relation to technical commissioning and validation, Currie & Brown did not provide advice or support as these activities were in the NEC Supervisor's remit. Currie & Brown did provide limited advice and support to the Board in discharging its NEC Project Manager functions in connection with the planning of the clinical commissioning. This clinical equipment included, e.g., MRI scanners and imaging equipment which was procured by the Board under separate agreements outside the Main Contract. Paul Fairie and I provided support in connection with planning the procurement, installation, and commissioning of these pieces of clinical equipment after the technical commissioning and handover of the new hospitals by Multiplex.

141 I have been referred to the original Memorandum of Understanding between Currie & Brown and the Board [**Bundle 17, Document No.40, Page 1938**] and asked whether this document is limited to '*the planning the procurement, installation, and commissioning of these pieces of clinical equipment after the technical commissioning and handover of the new hospitals by Multiplex'*. I was

not involved in the negotiation or agreement of this document and would defer to Douglas Ross in relation to the terms of the Memorandum. My understanding is that Currie & Brown's role in relation to commissioning was limited to commissioning of the clinical equipment which was outside of the Multiplex contract and unrelated to the subject matter of this Inquiry.

142 I have been asked whether this was the extent of Currie & Brown's role in respect of commissioning. Currie & Brown was not involved at all in the technical commissioning of the Hospitals.

143 I have been asked what role Currie & Brown had, if any, in the validation of the water and ventilation systems. Validation and testing was not part of Currie & Brown's role either.

144 I have been asked who was responsible for carrying out validation. Validation of the systems was a Board responsibility.

145 I have been asked what arrangements were in place to allow for validation to take place prior to handover. I was not involved and therefore do not know and am unable to comment on this.

146 I have been asked what awareness I had at the time of the lack of validation of the ventilation system prior to handover and what concerns I had regarding a lack of validation. I was unaware of the lack of validation of any areas prior to occupation.

Currie & Brown engagement with Wallace Whittle

147 I have been asked which M&E issues Currie & Brown engaged with Wallace Whittle on during the design and construction stage of the QEUH/RHC. Engagement with Wallace Whittle during the design and construction stage was very limited as in the construction phase the Board made the decision to refer design review of proposed alternative design solutions to Capita as NEC Supervisor. Multiplex were required to identify any alternative design solutions via Early Warning Notifications which is where potential M&E issues would be captured.

148 I have been asked about Multiplex directly engaging Wallace Whittle as part of its own technical team and whether Wallace Whittle was involved in the Project in two separate capacities. I do not recall this being a decision made by Multiplex. My recollection is that Wallace Whittle acquired ZBP, who were already part of the Multiplex design team.

149 Wallace Whittle, at that point, had been stood down by Currie & Brown, along with the rest of the Technical Team, following the change in Currie & Brown's role after the Contract was awarded to Multiplex. I understand that the Board used Capita in a support role to review alternative design solutions. I have been asked whether, with hindsight, this was the correct decision. As noted above, I believe that this was a commercial matter between Wallace Whittle and ZBP rather than a decision made by Multiplex.

150 I have been asked a series of questions regarding the Board's decision to forgo the requirement to have an independent commissioning engineer. In 2013 the Board issued a Project Managers Instruction ("PMI") (**Bundle 43, Volume 1, Document 50 page 245**) allowing Multiplex to assume the role of Independent Commissioning Engineer. The contractual requirement was for Multiplex to appoint the independent commissioning engineer (independent of Mercury Engineering who were the Mechanical Electrical and Plumbing (MEP) Subcontractor and who were undertaking the installations). Multiplex proposed David Wilson within their team as capable and competent to undertake the role.

151 I have been asked what the impact of this decision was and whether in hindsight it was the correct decision. Under the Contract, Multiplex were responsible for appointing the commissioning engineer. Given the contractual arrangement and requirements I don't think the fact that an internal Multiplex resource undertook the role made a material difference from a contractual point of view. As neither I nor Currie & Brown was involved in commissioning I do not know whether it made any other difference and so I cannot comment on whether this was the correct decision.

152 I have been asked to describe my involvement in the decision for the energy centre to be retained by Multiplex following handover as well as my knowledge of a payment being made by the Board to Multiplex in respect of the energy centre following it being handed over. To the best of my knowledge the energy centre was commissioned and was providing heat, power and emergency generation, when required, to the hospitals at the point of handover. I had no involvement in nor any knowledge of commercial matters post-handover relating to the Energy Centre as this post-dated my employment with Currie & Brown.

Handover

153 I have been asked who did the final inspections of the hospitals before handover in January 2015 and whether the hospitals were ready to be handed over at that point. Any questions in respect of final inspections and handover, including the contents of the Sectional Completion Certificate (**Bundle 12, Document No.3, Page 23)**, would be best answered by the Board Assistant Project Director, or Capita who issued the certificate of completion including the list of outstanding works/defects. I was not involved in any technical inspection or testing, although did participate in room reviews for clinical functionality as part of the wider project team.

154 I have been asked whether it was appropriate for the handover of hospitals to take place when the energy centre was not operational due to design issues. As far as I was aware, the energy centre was operational and providing power and heat to the hospitals at the point of handover. I left the Project in summer 2015 and subsequently left Currie & Brown in February 2016 and therefore my awareness of any defects that arose post-handover in relation to the energy centre is very limited.

155 I have been informed that the Inquiry understands that the energy centre was retained by Multiplex for two years and was not handed over. I have been asked whether I think it was appropriate for the handover of hospital to take place without the energy centre being handed over. It was not my understanding that the energy centre was not handed over at the same time as the Hospitals. There was a 2-year defects liability period for all works and it was my recollection and understanding that Multiplex undertook defect correction activities in this period.

156 I have been asked how the hospital came to be handed over without validation of the ventilation system and who was responsible for this. Validation and testing was not part of Currie & Brown's role and I was not personally involved. At this time my focus was on Group 5 equipment installation to the Imaging Departments including CT & MRI Scanners (Quarter 4 2014 to Q2 2015) therefore I am unable to comment on this.

157 I have been asked who was responsible for asset tagging, why there was no asset tagging prior to handover and who decided to proceed with handover in the absence of asset tagging. Asset tagging is a system that allows you to prepare the planned prepared maintenance schedule for the building and maintain assets in line with manufacturers' recommendations. I was not involved in asset tagging, nor was I engaged in the collation or acceptance of information on the Zutec document management system, which was designed to hold all as-built

information, such as drawings, O&M manuals and planned preventative maintenance schedule etc. The Board had not allocated me a Zutec licence because, whilst Currie & Brown had peripheral involvement in clinical commissioning of certain clinical equipment as I explained above, it had no involvement in the technical commissioning of the building. I therefore had no means to check what was contained in the files.

158 I have been asked to comment on a feasibility study to investigate a new location for the BMT Unit within the hospital which the Board commissioned Currie & Brown to prepare in November 2016. My direct involvement with the Project ceased in around May 2015 and I left the employment of Currie & Brown in February 2016 and so I am unable to comment on this. I am also unable to comment on Currie & Brown's involvement in any other works following handover for the same reasons.

Meeting with Dr Peters on 25 June 2015

159 I have read paragraph 34 of the witness statement provided to the Inquiry by Dr Christine Peters **Witness Bundle – Week Commencing 26 August 2024 – Volume 4, page 117**. Dr Peters refers to a meeting which she arranged and attended on 25 June 2015 with Dr Inkster, Ian Powrie of the Board, and a representative from Brookfield Multiplex. I am also noted to have attended as "*a representative from the Health Board commissioning team*". Dr Peters says that the Multiplex representative and I were unaware that the Infectious Diseases Unit and the BMT unit were on site at that time and did not know that the Infectious Diseases Unit was ever planned to be based at the QEUH.

160 As Currie & Brown was not involved in commissioning, neither I nor anyone else at Currie & Brown was a member of the Board commissioning team, and I do not

know why Dr Peters described me as such. I cannot recall attending this meeting, but I would probably have attended on behalf of Peter Moir, or at Peter Moir's request if he was unavailable to attend. Noting the time of year, Peter may have been on holiday, for example). By June 2015 I was no longer directly involved in the Project or based at the hospital and was working on projects in London.

161 I was aware that the BMT Unit was moving into the hospital, but as I was no longer directly involved in the Project by June 2015 I may not have been fully up to speed on that at the time. I don't recall ever being informed or being aware that the Infectious Diseases Unit would be moving into the hospital. Dr Peters says that I stated I would discuss these issues with David Loudon after the meeting. Whilst I cannot specifically recall speaking with David Loudon, I expect that I would have done so if I said I would.

162 I have been asked to describe my working relationship with Capita, Multiplex, Mercury, Wallace Whittle and the NHS GGC Project Team during the course of the project. My working relationship was, as required by the NEC form of contract, both professional and collaborative. All parties were working proactively together for the benefit of the project.

163 I have been asked to describe any difficulties I experienced in those working relationships. Whilst there were many challenges in the Project, these were dealt with professionally and collaboratively.

164 I have been informed that the Inquiry has heard evidence from a number of witnesses in the August 2024 hearings that suggests that the QEUH/RHC site looked like a building site at handover. I have been asked what I would say to this. This may have appeared the case as in the period post January 2015 there were significant activities ongoing that were outside the Multiplex contract primarily related to Group 5 equipment installation. The Board procured all of this equipment directly and much of it was installed in the period February 2015 to May 2015.

Declaration Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signed:  Print name: David Hall

Scottish Hospitals Inquiry In respect of the Glasgow IV, Part 1 Hearing Commencing 13 May 2025

The witness was provided the following Scottish Hospital Inquiry documents for reference when they completed their questionnaire statement.

Appendix A

A47069198 - Scottish Hospitals Inquiry - Hearing Commencing 19 August 2024 - Bundle 12 - Estates Communications (External Version)

A47664054 - Scottish Hospitals Inquiry - Hearing Commencing 19 August 2024 - Bundle 15 - Water PPP (External Version)

A47851278 - Scottish Hospitals Inquiry - Hearing Commencing 19 August 2024 - Bundle 16 - Ventilation PPP (External Version)

A49342285 - Scottish Hospitals Inquiry - Hearing Commencing 19 August 2024 - Bundle 17 - Procurement History and Building Contract PPP (External Version)

A48743262 - Scottish Hospitals Inquiry- Hearing Commencing 13th May 2025 Bundle 43 Volume 2-Procurement Contract Design and Construction Miscellaneous documents

A48032049 – Scottish Hospitals Inquiry- Hearing Commencing 13th May 2025 - Bundle 47 Volume 8 – Critical Care Drawings and Room Data Sheets

A35809031 – Scottish Hospitals Inquiry- Hearing Commencing 13th May 2025- Bundle 47 Volume 8- Critical Care Drawings and Room Data Sheets

The witness provided the following Scottish Hospital Inquiry documents for reference when they completed their questionnaire statement.

Appendix B

N/A

Appendix C

EXHIBIT SHEET

This is exhibit **DH1** referred to in the witness statement of David Hall David B Hall FCIOB, MAPM.

EMPLOYMENT

University of Glasgow, Estates Directorate University Avenue, Glasgow G12 8QQ

Director of Projects – September 2023 to present Project Director (Campus Expansion) – November 2018 to September 2023 Head of Construction & Project Management – February 2016 to October 2018

Initially appointed as Head of Construction & Project Management with an overarching role to deliver both the campus redevelopment and expansion into the former western infirmary site, I, at the request of University Senior Management Group and Estates Committee, re-focused primarily upon the campus expansion in 2018 and assumed

responsibility for the design development and construction of 7 major new builds and the associated infrastructure project.

Projects completed include:

- The James McCune Smith Leaning Hub
- The Mazumdar Shaw Advanced Research Centre
- The Clarice Pears School of Health & Wellbeing
- The Adam Smith Business School & PGT Hub
- Western Infrastructure Phase 1

Projects Currently in the design phase include:

- Keystone
- Student Residencies
- Innovation Building

Currie & Brown UK Limited, Building 3, 2 Parklands Avenue Maxim Office Park, Eurocentral, Lanarkshire, ML1 4WQ

May 2000 – February 2016 Senior Project Manager (circa 2000 to 2004) Associate Director (circa 2004 to 2007) Divisional Director (circa 2007 to 2010) Director (2010 to 2016)

Working across a variety of sectors including healthcare, financial institutions, retail, and commercial we delivered multi-disciplinary services to clients utilising both internal and external resources tailored to meet the project needs.
Projects Completed included:

- New South Glasgow Hospitals

- Community Resource Centre: Coatbridge
- Community Health Centre: Airdrie
- City Centre Office Rationalisation Strategy: Glasgow
- Banking Automation: UK & Ireland
- Commercial Development: Newcastle

Safeway Stores plc, Melford Road, Righead Industrial Estate, Bellshill ML4 3DD
Senior Project Manager, January 1996 to May 2000

Initially employed in the Property Department as a Regional Building Surveyor with responsibility for facilities management and minor capital expenditure within a group of 25 large Safeway superstores in Scotland East, I quickly progressed into the refits and extensions project management team which was subsequently combined with the new stores team.

Projects completed included: ○ Roll-out programme of third party ATMs into stores throughout the UK ○ Installation of third party financial units into stores.
○ Construction of new stores in Greenock and East Kilbride ○ Major Extensions in Glasgow, Edinburgh, Fort William and Aberdeen

William Hill Organisation Limited, 9-15 North Drive, Glasgow G1 4BL

Regional Building Surveyor April 1992 – December 1995

Regional Building Surveyor, reporting to Property Director, I was responsible for the property portfolio across Scotland ensuring that all statutory requirements were met and properties were maintained to a functional standard.

Responsibilities & Projects completed:

○ Responsible for Facilities management of circa 200 retail units across Scotland. ○ Implementation of electronic purchasing system to replace manual system ○ Minor refits programme to 20 stores/annum

The Miller Partnership, 9 Royal Crescent Glasgow, G3 7SX,

Senior Architectural Assistant January 1990 – April 1992

A senior architectural assistant reporting to the project architect on the design and construction of a number of stadia developments and refurbishments with responsibility to manage and deliver the technical detailing and coordination of the wider design team.
Projects Completed:

○ The New Den, Millwall, London
○ The City Ground, Nottingham ○
Firhill Stadium, Glasgow ○ Murrayfield
Stadium, Edinburgh

J.G. Wallace Architects, St Vincent Place Glasgow, G1 2EU Architectural Assistant July 1985 – December 1989

An architectural assistant reporting directly to the partner in charge, I was responsible for the design development and statutory approvals on a range of commercial and residential projects including:

- Various branch extensions and refurbishments for Clydesdale Bank plc
- Office Development @ 176 Bath Street Glasgow
- Sheltered Housing development. Pollokshields, Glasgow

GD Lodge & Partners, Empire House, 131 West Nile Street, Glasgow, G1 2RX

Architectural Trainee August 1982 – June 1985

An architectural trainee reporting to project architects, I was responsible for providing drafting support on a variety of projects including:

- Various branch extensions and refurbishments for Clydesdale Bank plc
- Residential development master-plans
- Restaurant fit-outs for Pizzaland

EDUCATION

Professional Fellow of the Chartered Institute of Building

Metropolitan College, Glasgow Direct Membership Examinations

Member of the Association for Project Management

Experienced Practitioner Route Direct Membership Application

Accredited RICS Mediator Accredited NEC4 Project Manager Further Education Glasgow College of Building & Printing North Hanover Street, Glasgow

Qualifications: Higher National Certificate in Architectural Technology, National Certificate in Building